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Office of Administrative Law Judges
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Issue Date: 29 December 2006

In the Matter of

K.W.S.

Claimant

Case No. 2005-BLA-05958

v.

CANADA COAL CORPORATION
Employer

and

ZURICH AMERICAN INSURANCE
GROUP
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-In-Interest

Appearances: Joseph Wolfe, Esq.
Wolfe, Williams & Rutherford
For the Claimant

J. Lawson Johnston, Esq.
Dickie McCamey & Chilcote, P.C.
For the Employer

Before: William S. Colwell
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR

§ 718.201 (2004). In this case, the Claimant, K.W.S., alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 13, 2005 in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Director's Exhibits ("DX") 1-42, Administrative Law Judge Exhibits ("ALJX") 1-3, Claimant's Exhibits ("CX") 1-4¹, and Employer's Exhibits ("EX") 1-5 were admitted into evidence without objection. Transcript ("Tr.") at 9, 7, 11, 14, 15, 17, 20-22, 24-25. The parties were allowed to file post-hearing briefs. Claimant's brief was received March 29, 2006, and Employer's brief was received March 30, 2006. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

¹ In his Black Lung Benefits Act Evidence Summary Form dated March 29, 2006, Claimant lists Dr. M.J. Thakkar's September 19, 2005 medical report as CX 1 and Dr. Alexander's reading of the August 9, 2004 x-ray as CX 2. These designations coincide with Claimant's attorney's representations at the hearing. Tr. 10-13. The transcript further establishes that neither exhibit was provided at the hearing:

MR. WOLFE: Yes, sir, we do, Your Honor. If I could have just one second. One of the exhibits I mentioned with Dr. Thakkar I was – we had faxed that in to Your Honor and to Mr. Johnston on the 23rd of September. He may not have gotten that.

JUDGE COLWELL: I'm not sure if we have either. I don't see it in my information. In my Order I asked that all evidence submitted at the hearing and not be, so we return all evidence that's submitted before the hearing. I mean, if you have a copy, that's fine, but I don't have it.

...

JUDGE COLWELL: Right now you don't have a copy of that exhibit?

MR. WOLFE: We do, Your Honor, and I've – that may be the only copy. I can – after the hearing I can make a copy down the hall here and submit that.

JUDGE COLWELL: That'd be fine.

MR. WOLFE: Okay.

...

MR. WOLFE: Your Honor, we had previously submitted an x-ray report of Dr. Alexander and it's listed under the Director's exhibits as Director's Exhibit Number 38, although the 8 is sort of marked out. We had exchanged that with Mr. Johnston back in January, but unfortunately the Director did not include that reading with the cover letter. And, so, we will be submitting that specific reading. I can make that Claimant's Exhibit Number 2. I've just got to locate it in my papers. It's been exchanged and we marked it on our Pre-Trial Summary Form and I saw it here just a minute ago.

If we could have just a minute.

I thought it was in the Director's exhibits and I see that it was not.

...

MR. WOLFE: I can submit that post-hearing, Your Honor. In fact, I'll probably find it by the end of the hearing.

Tr. 10-14. Despite a thorough search, neither of these two exhibits appears of record. Therefore, they cannot be considered. Claimant's evidence summary form also lists CX 5-9, but these were never offered into evidence or received. Consequently, they cannot be considered either.

PROCEDURAL HISTORY

The claimant filed his application for benefits on March 29, 2004. DX 3. The District Director issued a Proposed Decision and Order – Award of Benefits dated January 24, 2005. DX 29. The employer requested a hearing on February 11, 2005, and the claim was referred to this office on May 25, 2005. DX 32, 40.

APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he is totally disabled, and that the pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004).

ISSUES

After the hearing, the following are the remaining contested issues:

1. Whether the miner worked as a miner after December 31, 1969.
2. Whether the miner worked for at least 18 years in or around one or more coal mines.
3. Whether the miner has pneumoconiosis.
4. Whether his pneumoconiosis arose out of coal mine employment.
5. Whether he is totally disabled.
6. Whether his total disability is due to pneumoconiosis.
7. Whether Canada Coal Corporation is the responsible operator.

DX 40; Tr. 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Claimant testified to the following. Tr. 26-44. He was born December 1, 1957 and was 47 years old at the time of the hearing. He married K.G. on February 16, 1990, DX 9, and they have a daughter, J.L., who was born on January 6, 1991. DX 11.

Mr. K.W.S. testified that he worked as a coal miner for over 18 years. He last worked for Canada Coal as a roof bolter. He worked there for about two years, ending in 1998. Prior to his work as a roof bolter, the miner also worked as a shuttle car and scoop operator. He described the shuttle car as a large conveyor belt on two wheels. It transports tons of coal to the main line. The work is considered at the face of the mine and also entails avoiding running over cables. As a roof bolter, Mr. K.W.S. drilled holes, often three to four feet deep, in the top. After the bolt was in the top, he'd place a six-inch plate on the bottom. The Claimant stated that he worked for Canada Coal for part of 1996, all of 1997, and part of 1998. He last worked in February 1998 just before the mine closed down. After that, he worked in non-coal mining employment until May 2005.

Mr. K.W.S. testified that he smoked eight to ten cigarettes a day for 27 years, from the age of 16 to 43. He currently treats with Dr. Thakkar for cardiomyopathy. He takes Lanoxin, Coreg, Lasix, Prevacid, potassium, and aspirin. He takes no medication for his lungs. However, he testified that his biggest problem is his breathing. He wheezes after very little activity and believes he could not return to coal mine employment.

Length of Coal Mine Employment and Responsible Operator

Claimant alleges 18 years of coal mine employment. On his Employment History form, Mr. K.W.S. listed the following coal companies and years of employment:

Black Gold	1979-80
Jewell-Ridge	1980-82
Mago Coal	1982
Little Legion Coal	1982-89
Beektom Mining	1989-90
Middle Creek Energy	1990-96
Terry Lynn Coal	1996
Canada Coal	1996-98.

DX 4. This accounts for 18-19 years of coal mine employment. The Social Security records confirm the following coal mine employment:

Jewell Ridge Coal Corp.	1980-82	12 quarters
Pyramid Mining Inc.	1984-85	8 quarters
Mabo Coal Company Inc.	1986-87	4 quarters
River Bend Mining Inc.	1987	1 quarter
Middle Creek Energy Inc.	1989-95	25 quarters
Chad Coal Corp.	1995	1 quarter
Terrie Lynn Coal Co.	1996	4 quarters
Canada Coal Corp.	1996-98	7 quarters
Total		62 quarters = 15.5 years

DX 7. The miner's W-2 forms verify the Social Security earnings. DX 6. Mr. K.W.S. stated that he worked for many small truck mines that often closed. He worked eight- to nine-hour-shifts for those companies. When he worked for Canada Coal, he was paid \$100 a day. The W-2 forms show that he earned over \$14,940 in 1996, \$27,553 in 1997, and \$2,781 in 1998. Thus, he worked over 149 days for Canada Coal in 1997, 273 days in 1998, and 27 days in January and February 1998.

Based on this information, I find that Mr. K.W.S. worked as a coal miner after December 31, 1969. I also find that Canada Coal Company was Mr. K.W.S.'s last coal mine employer for at least one year. It is the properly named responsible operator. Finally, because I find the Social Security records the most credible evidence, I determine that Mr. K.W.S. has established 15.5 years of coal mine employment and that his last coal mining job for at least one year was as a roof bolter with the exertional requirements he described in his hearing testimony.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 (2004) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).² If no qualifications are noted for any of

²NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray/reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 15 8/9/04/ 8/9/04	Patel B, BCR	1/0/Quality 1	Positive (OWCP evaluation)
DX 16 8/9/04/ 9/1/04	Barrett B, BCR	Quality 1	Used by District Director for quality reading only ³
EX 2 8/9/04/ 9/10/05	Lautin B, BCR	Negative; ill-defined non-calcified 2 cm nodule over right mid-lung/Quality 2	Negative (Employer's rebuttal of DX 15)
EX 1 12/2/04/ 12/3/04	Stewart B	Negative for pneumoconiosis; 1 ½ cm nodule--suspected cancer/Quality not noted	Negative (Employer's evaluation)

Pulmonary Function Tests

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If there is greater resistance to the flow of air, there is more severe lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV₁) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 (2004) and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the FEV₁ must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the

³ Used by the District Director (DD) for a quality reading only. This reading was not submitted or mentioned by either party; and thus, I will not consider it other than as a reading for film quality.

applicable table value, or the FEV₁/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Test Date Physician	Age Height	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 14 5/12/04 Rasmussen	46 72"	4.32	5.83	74%	---	No	Normal
EX 1 12/2/04 Stewart	47 73"	Not given	Not given	Cannot be determined	---	Unknown	Mild obstructive defect with mild improvement after bronchodilator

Arterial Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO₂) and the percentage of carbon dioxide (PCO₂) in the blood. A lower level of oxygen (O₂) compared to carbon dioxide (CO₂) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO ₂ at rest/ exercise	PO ₂ at rest/ exercise	Qualify?	Physician Impression
DX 14	5/12/04	Rasmussen	34/36	80/75	No/No	Normal; Found by Dr. Stewart to indicate submaximal effort or severe deconditioning but not a lung problem per se. EX 1c.

CT Scans

On September 28, 2000, Mr. K.W.S. underwent a CT scan that was read by Dr. Harry G. Kennedy, Jr. CX 3. He found no evidence of a hilar mass lesion and felt that the density in the right lower lung field appeared to be vascular.

On October 30, 2003, Claimant underwent a CT scan of the chest. CX 3. Dr. Nripendra C. Devanath read the scan as revealing moderate diffuse pulmonary emphysema with moderate fibrosis in the lower lobes of both lungs, and a mass measuring 2 cm x 2 cm x 1.5 cm in the posterior edge of the right middle lobe. He felt it was highly suspicious for carcinoma of the lung.

On March 26, 2004, Mr. K.W.S. underwent a second chest CT. CX 3. Dr. Nancy Hallo interpreted the scan and found a stable 2.0 x 2.0 x 1.3 cm nodule in the right middle lobe that showed no significant change from October 30, 2003.

A December 22, 2004 CT scan of the chest was read by Dr. Harry G. Kennedy, Jr., who was unable to identify the pulmonary nodule in the right middle lobe described on previous studies CX 3.

Mr. K.W.S. underwent a CT scan of the chest on May 20, 2005. CX 4. Dr. Ernest Coburn interpreted the scan and found that when compared with the March 26, 2004 CT scan, the mass in the right middle lobe measured 2 cm x 1.3 cm and was unchanged in size. He added, "There is suggestion that the nodule is from coal workers' pneumoconiosis. This is not typical for progressive massive fibrosis or coalescence. There is not a background of interstitial changes associated with the lesion or retraction into the lesion or bleb formation along the margins." However, in an addendum dated March 23, 2005, Dr. Coburn stated that he had considered the November 7, 2003 biopsy report and reformed his opinion: "I have suggested that this was not a typical finding for pneumoconiosis but this does indeed represent changes from pneumoconiosis with progressive massive fibrosis." Thus, his final impression was, "Progressive massive fibrosis which is atypical but by biopsy is associated with the patient's pneumoconiosis."

Biopsy Evidence

Because of a right lung lesion, Mr. K.W.S. underwent both a fine needle aspiration and a core needle biopsy of the right lung on November 6, 2003. DX 13. Dr. Marcus C. Grimes provided the cytopathology report dated November 7, 2003. He provided both gross and microscopic descriptions. He found focal fibrosis associated with abundant carbonaceous debris. Dr. Grimes commented:

Birefringent particulate debris is visible under polarized light within the areas of fibrosis. The microscopic findings raise the concern of localized pulmonary fibrosis secondary to occupational exposure, (possibly coal worker's [sic] pneumoconiosis if the clinical history is concordant).

Dr. Joseph F. Smiddy provided a cover letter dated February 10, 2004, addressed to Mr. K.W.S., explaining that he believed that the finding of “carbonaceous particulate material and carbonaceous debris” was related to occupational exposure and represented complicated pneumoconiosis. DX 13.

Dr. Everett F. Oesterling reviewed the biopsy evidence on September 19, 2005. EX 4. He considered the surgical pathology report and the digital photomicrographs. Dr. Oesterling, who is board certified in anatomic and clinical pathology as well as nuclear medicine, found:

Based on the material made available there is evidence of macular dust disease consistent with coal mine dust exposure. There is, however, no confluent fibrosis to indicate progressive massive fibrosis. The pattern is merely that of a moderate macular coal workers’ pneumoconiosis. Based on this level of change there would appear to be insufficient structural change to significantly alter pulmonary function, thus no disability would be anticipated with this level of coal workers’ pneumoconiosis.

Dr. Oesterling noted that the extent of the CWP would appear quite limited because only a singular lesion was collected.

Dr. Oesterling was deposed on October 12, 2005. EX 5. He testified that the maximum dimension of either of the two cores of tissue was less than a centimeter so the diagnosis of complicated pneumoconiosis could not be made based on size alone and because there must be multiple nodules that have been drawn into a confluent mass. Dr. Oesterling explained that needle biopsies are primarily performed to diagnose or rule out cancer. They collect very few cells. He admitted, however, that in this case, the retrieved cells were sufficient to diagnose CWP. He referred to Bryan Corrin’s text, Pathology of the Lungs, which says that the needle biopsy is adequate for diagnosing tumors but is not appropriate and rarely successful in diagnosing interstitial lung disease. The text further stated that an open wedge biopsy would be needed to get enough lung tissue to diagnose or rule out the presence of complicated pneumoconiosis. Dr. Oesterling agrees with this statement. Dr. Oesterling also testified that he disagrees with Dr. Smiddy’s conclusion that the biopsy evidence pointed to complicated pneumoconiosis. He found only macular pneumoconiosis which he explained is the very low level of simple CWP. No collagen or scar tissue was present, as is the case with complicated CWP.

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis is a substantially contributing cause of the miner’s disability. A determination of the

existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. See 20 CFR § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

Where total disability can not be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). Quality standards for reports of physical examinations are found at 20 CFR § 718.104 (2004). The record contains the following medical opinions relating to this case.

Dr. Rasmussen

Claimant was examined by Dr. D.L. Rasmussen on behalf of the Office of Workers' Compensation Board on May 12, 2004⁴. DX 14. Dr. Rasmussen considered 18 years of coal mine employment, mostly and lastly as a roof bolter, family history, a medical history significant for congestive heart failure secondary to cardiomyopathy and a right lung mass indicating complicated coal workers' pneumoconiosis, and a history of having smoked about one-half pack of cigarettes a day for 26 years before quitting in 1999. Claimant complained of shortness of breath for five to six years, dyspnea on stair climbing or walking in the woods, wheezing with exertion, and some ankle swelling. Physical examination revealed moderately reduced breath sounds with a few crackles but no rhonchi or wheezes. Dr. Rasmussen considered the results of an x-ray, a pulmonary function study, a blood gas study, and EKG. He was also apprised of the CT scan results of October 30, 2003 and March 26, 2004, and the results of a November 6, 2003 lung biopsy. He diagnosed complicated coal workers' pneumoconiosis based on the length of coal mine employment, the x-ray, CT scans, and biopsy reports. He believes it arose from the miner's coal mine employment. Dr. Rasmussen found the miner's lung function to be essentially normal and opined that he retains the pulmonary capacity to perform his last regular coal mine job. Dr. Rasmussen is board certified in internal medicine and forensic medicine.

⁴ Claimant shows Dr. Rasmussen's examination and laboratory tests as having taken place on August 9, 2004. Although that is the date of the x-ray read by Dr. Patel, Dr. Rasmussen examined the Claimant on May 12, 2004.

Dr. Stewart

Dr. Bruce N. Stewart examined the miner on December 2, 2004, at the request of the Employer. EX 1a. Dr. Stewart considered 18 years of coal mine employment, mostly as a roof bolter, family history, a medical history significant for hypertension and cardiomyopathy, and a history of having smoked about one-half pack of cigarettes a day for 27 years before quitting in 2000. Claimant complained of shortness of breath for the last two years, sometimes even at rest. Physical examination revealed clear lungs. Dr. Stewart considered the results of an x-ray and a pulmonary function study. He diagnosed a right lung mass, history of cardiomyopathy, history of hypertension, and mild eventration of the right hemidiaphragm. He didn't find sufficient objective evidence to diagnose coal workers' pneumoconiosis. He felt there was no evidence of complicated CWP, adding, "a fine needle aspiration biopsy is [not] able to obtain enough tissue to diagnose coal workers' pneumoconiosis in the first place." Dr. Stewart asserted that with essentially normal lung fields, it would be most unusual to find an isolated single mass due to CWP. (He clarified this statement in his deposition. There he stated that when an x-ray fails to show any pneumoconiosis, it would be unusual to have complicated pneumoconiosis. EX 3, p. 23-24.) In his opinion, the mass most likely represents either a primary neoplasm or a granuloma from a prior infection.

Dr. Stewart reviewed additional medical evidence for a report dated December 9, 2004. EX 1b. He considered Dr. Rasmussen's report, PFT, and ABG, the x-ray reports of Drs. Patel and Barrett, Dr. Smiddy's February 10, 2004 letter, and the cytopathological and surgical pathology reports of November 7, 2003. Based on the additional data, Dr. Stewart found nothing that would change his opinion that there is not sufficient evidence to diagnose CWP or a respiratory impairment.

Dr. Stewart was deposed on October 12, 2005. EX 3. Dr. Stewart provided his credentials. He is board certified in internal medicine and pulmonary disease and has examined coal miners for 35 years. He explained that cardiomyopathy is a weakening of the heart muscle caused by a virus or a blockage of the blood vessels. It can lead to shortness of breath and fluid retention. Dr. Stewart reviewed Dr. Grimes's report regarding the needle biopsy of the right lung. Based on his review of the literature and his personal knowledge, he felt it could not gather adequate tissue to diagnose CWP. Based on the miner's respiratory system, Dr. Stewart felt Mr. K.W.S. could return to his last coal mining job.

Hospital and Treatment Notes

The record contains treatment notes from Clinch Valley Medical Center from October 12, 2000 to July 2004. CX 3. Among these records are the progress notes of Dr. Thakkar that run between October 2000 and July 2004. They reveal that Dr. Thakkar examined the miner approximately 30 times during that time period. He considered complaints, the results of CT scans, biopsy, laboratory work, and physical findings. His diagnoses include controlled congestive heart failure; episodes of light-

headedness and dizziness; hypoxia; and advanced coal workers' pneumoconiosis. An October 2000 PFT showed no respiratory function impairment.

In a letter dated February 10, 2004, Dr. Joseph F. Smiddy wrote to Dr. Thakkar regarding the biopsy of November 2003. He stated that the "disease process may be complicated Coal Workers' Pneumoconiosis causing both the lymphadenopathy and the nodule in the right lung although certain multiple concomitant diagnoses are not excluded and occult malignancy is not totally excluded at this point."

Mr. K.W.S. was hospitalized on November 17, 2000 for cardiac catheterization and angiography. CX 3. Dr. Thakkar attended him and noted complaints of shortness of breath for two months. Medical history was significant for hypertension and hyperlipidemia. Dr. Thakkar noted 18 years of coal mine employment and a history of smoking one-third pack of cigarettes a day for about 26 years before quitting a couple of months ago. Based on the catheterizations and angiograms, Dr. Thakkar diagnosed mild irregular distal segment of the right coronary artery; elevated left ventricular end diastolic pressure; and wall motion abnormality of the superolateral and posterolateral segment of the left ventricle.

DISCUSSION AND APPLICABLE LAW

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or

pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, “pneumoconiosis” is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I must consider the chest x-rays, biopsy evidence, CT scans, and medical opinions, as all four categories of evidence are applicable in this case. As this claim is governed by the law of the Fourth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a).

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp.*, 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the three available x-ray readings in this case, one was considered positive for pneumoconiosis while two were found to be negative. There is also one reading made for quality purposes only. For cases with conflicting x-ray evidence, the regulations specifically provide,

Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2004); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Scheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; see *Adkins*, 958 F.2d at 52. Finally, a radiologist's academic teaching credentials in the field of radiology may be relevant to the evaluation of the weight to be assigned to that expert's conclusions. See *Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-108 (1993).

Analysis of X-Ray Studies

The August 9, 2004 x-ray was found positive by Dr. Patel, a B-reader and board-certified radiologist. He also found it to be of the best quality for interpretation purposes. Dr. Barrett read the x-ray for quality purposes only and found it to be quality 1. He too is a dually certified reader. Dr. Lautin, another dually certified reader, felt the x-ray was negative for pneumoconiosis and quality 2. Because equally qualified readers came to opposite conclusions, I find that this x-ray is in equipoise and that it must be considered negative.

The December 2, 2004 x-ray was found negative for pneumoconiosis by Dr. Stewart, a B-reader. It was not reread. Consequently, I find this x-ray to be negative. For the foregoing reasons, I find that the x-ray evidence does not tend to establish, by a preponderance of the evidence, the existence of pneumoconiosis.

Analysis of Biopsy Evidence

A biopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish the existence of pneumoconiosis.

The biopsy in this case was conducted in compliance with § 718.106. Dr. Grimes, the pathologist, made a finding of pulmonary fibrosis secondary to occupational exposure, which he felt was possibly CWP. Dr. Oesterling reviewed the biopsy evidence and concluded that it revealed CWP. Dr. Grimes's finding was couched in equivocal terms because he was not aware of Mr. K.W.S.'s clinical or occupational history. Therefore, I place some weight on his finding but discount it to the extent that he felt CWP was merely "possible." *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Dr. Oesterling is a board certified pathologist, and I place great weight on his opinion based on his qualifications. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). He had the opportunity to review the digital photomicrographs, and I find his opinion well documented and reasoned. Accordingly, I find that the biopsy evidence establishes the existence of pneumoconiosis.

Analysis of Evidence Under § 718.304

Pursuant to § 718.202(a)(3), a miner will be presumed to suffer from pneumoconiosis if one of the presumptions described in §§ 718.304, 718.305, or 718.306 is applicable. In this case, the irrebuttable presumption of § 718.304 must be addressed. A miner will be considered totally disabled if the irrebuttable presumption of Section 718.304 applies to his claim. The irrebuttable presumption set forth at Section 718.304 provides that if a miner is suffering from chronic dust disease of the lung which yields one or more large opacities on chest x-ray which would be classified as Category A, B, or C or one or more massive lesions on biopsy, then such miner shall be presumed to be totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(b), 20 C.F.R. § 718.304.

In this case, none of the x-rays was read as showing large opacities that the physicians felt represented complicated pneumoconiosis. Of the five CT scans, a 2 cm mass in the right lung was first found on the October 30, 2003 CT scan. It was not until the May 20, 2005 scan was read by Dr. Coburn that any physician suggested it might represent CWP. He felt the finding was not typical for complicated pneumoconiosis because of the lack of interstitial changes in the background. However, after considering the biopsy report, he changed his opinion and stated that the nodule represented progressive massive fibrosis despite the atypical presentation.

Regarding the biopsy evidence, Dr. Smiddy felt that the nodule represented complicated pneumoconiosis. Dr. Oesterling opined that the biopsy established simple CWP but not complicated pneumoconiosis. Dr. Rasmussen diagnosed complicated pneumoconiosis based on the biopsy report, CT scan, x-ray, and coal mine employment history of the miner. In his progress notes, Dr. Thakkar diagnosed advanced CWP but did not identify it as “complicated pneumoconiosis.”

Of these opinions, I find those of Drs. Coburn and Oesterling to be the most probative. Dr. Coburn is a radiologist who considered the CT scan and the biopsy report. Dr. Oesterling is a pathologist who viewed the photomicrographs and considered the biopsy report. The opinions of Drs. Rasmussen, Smiddy, and Thakkar are based on less direct data. There is no indication that they directly viewed the biopsied tissue or the CT scans.

Dr. Oesterling’s opinion that the miner does not have complicated CWP is based on the absence of confluent fibrosis. He further deposed that the maximum size of the two tissue samples was less than one centimeter based on the needle’s size. He relied upon a medical text for support that a large sample of tissue is needed to diagnose complicated CWP by biopsy.

Dr. Coburn based his opinion on his CT scan reading and the biopsy report. Like Dr. Oesterling, Dr. Coburn initially believed that the singular nodule without a background of interstitial changes was too atypical a presentation for CWP. However,

after being confronted with the biopsy report, he made the diagnosis of complicated CWP based on the nodule's size, despite the atypical presentation.

I find Dr. Coburn's reasoning and conclusion more persuasive. Section 718.304 requires a finding of one or more large opacities on chest x-ray which would be classified as Category A, B, or C or one or more massive lesions on biopsy. Dr. Coburn confirmed, by CT scan, the presence of a large mass greater than one centimeter in diameter. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA-A (Sept. 27, 1996). That nodule was biopsied and, despite the Corrin text and the personal experience of Drs. Oesterling and Stewart, and Coburn himself, it was diagnostic of CWP. Based on that diagnosis and the fact that the nodule measured 2 cm as far back as October 30, 2003, Dr. Coburn determined that Mr. K.W.S. suffers from complicated CWP. Dr. Oesterling provided reasons why, despite the size of the nodule and the pathological evidence of CWP, the disease is not complicated pneumoconiosis. He pointed out that there was an absence of coalescence and background of interstitial changes. However, the regulations do not require a medical or pathological standard of complicated pneumoconiosis. *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000). Dr. Oesterling failed to state whether the lesion met the statutory definition of the disease. For these reasons, I place greater weight on Dr. Coburn's opinion and discount Dr. Oesterling's. Thus, I find that Mr. K.W.S. has established, by a preponderance of the evidence, that he suffers from complicated pneumoconiosis according to the CT scan and biopsy evidence. As a result, he is entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis, and he is entitled to benefits.

Analysis of Medical Opinions

Medical Opinion Guidance

Despite my finding regarding § 718.304, I will analyze the remaining evidence for purposes of completion. I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's

opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in ... weighing ... the medical evidence ..." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004).

Balancing Conflicting Medical Opinions

After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Rasmussen and Thakkar for the reasons stated below.

Dr. Rasmussen and Dr. Thakkar diagnosed pneumoconiosis. Dr. Coburn also found CWP based on the CT scan, as supported by the biopsy report. Drs. Kennedy, Devanath, and Hallo, who read previous CT scans, did not diagnose CWP. Dr. Stewart found that the evidence was insufficient to establish CWP.

I place great weight on Dr. Rasmussen's opinion because it is well reasoned and documented. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). Although the x-ray on which relied is not part of the record for consideration, the CT scan reports and biopsy report he reviewed clearly support his conclusion. I also place great weight on Dr. Thakkar's opinion because of his status as the miner's treating physician. § 718.104(d). Dr. Thakkar has treated Mr. K.W.S. since October 2000, including for respiratory conditions. He has seen him with great frequency as evidenced by 30 office visits in fewer than four years, and he has considered the results of physical examinations, x-rays, the biopsy report, and CT scans—the types of testing and examinations that demonstrate superior and relevant information concerning the miner's condition. For the foregoing reasons, and while I note the contrary, probative opinion of Dr. Stewart, I place controlling weight on the opinions of this treating physician. § 718.104(d)(5). I also place great weight on Dr. Coburn's CT scan reading for the reasons listed above.

On the contrary, I find Dr. Stewart's opinion to be poorly reasoned. Despite reading the biopsy report, Dr. Stewart, unlike Drs. Oesterling, Coburn, and Rasmussen, continued to insist that the fine needle biopsy could not gather enough tissue to diagnose CWP. Even the Corrin text states that a needle aspiration is rarely successful in diagnosing interstitial lung disease, leaving room for the possibility that such an aspiration can sometimes retrieve sufficient tissue for diagnosing CWP. Because Dr. Stewart's opinion flies in the face of the best evidence in this case—I find his conclusion poorly reasoned. Accordingly I place reduced weight on Dr. Stewart's opinion.

I determine that Dr. Rasmussen and Dr. Thakkar's opinions, as supported by Dr. Coburn's, are the best documented and reasoned medical opinions. Therefore, I conclude that Mr. K.W.S. has established the existence of pneumoconiosis pursuant to § 718.202(a)(4). Further consideration of all the medical evidence under § 718.202(a) leads me to also conclude that the biopsy evidence, combined with the CT scan evidence and the most logical and credible medical opinions, establishes the existence of pneumoconiosis.

Pneumoconiosis Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). I have found that Mr. K.W.S. has established 15.5 years of coal mine employment. Accordingly, he is entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment. Employer has not provided sufficient evidence to rebut that presumption.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment. 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2004). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from cor pulmonale. Thus, I will consider pulmonary function studies, blood gas tests, and medical opinions.

Pulmonary Function Tests

There are two PFTs. The May 12, 2004 study did not produce qualifying values. The December 2, 2004 study is not in the record. The values generated from that test cannot be determined. Thus, it is of no value. Based on the non-qualifying study of May 12, 2004, however, I find that Claimant has not established total disability pursuant to § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Neither the at-rest nor the after-exercise study of May 12, 2004 yielded qualifying values. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(2)(ii).

Medical Opinions

Dr. Oesterling anticipated no disability based on the biopsy findings of the level of CWP present. Dr. Rasmussen opined that the miner retained the pulmonary capacity to perform his last coal mining job. Dr. Stewart also felt that the miner could return to his last coal mining job. Because this opinion is unanimous, I find that the medical opinion evidence does not support a finding of total disability.

Summary

In the instant case, the medical opinion evidence, pulmonary function studies, and blood gas studies clearly point to a finding that the miner is not totally disabled. Therefore, I find that Mr. K.W.S. has failed to establish, by a preponderance of the evidence, that he is totally disabled by a pulmonary or respiratory impairment. This finding, however, does not negate the finding that he is entitled to the irrebuttable presumption that he is totally disabled due to pneumoconiosis pursuant to § 718.304.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish the existence of total disability due to pneumoconiosis. Consequently, he is entitled to benefits under the Act.

ATTORNEY FEES

No award of attorney's fees for services to Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to §§ 725.365 and 725.366 of the Regulations. A service sheet showing service upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of K.W.S. for black lung benefits under the Act is hereby GRANTED, and it is hereby ORDERED that the employer, Canada Coal Corporation, shall pay to Claimant, K.W.S., all augmented benefits to which he is entitled under the Act, commencing March 1, 2004.

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WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:pah

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).